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DEPENDENT CARE ASSISTANCE EXPENSES  
REIMBURSEMENT REQUEST FORM

Employer Name		Branch Location		Group No.
Employee's Last Name		First	M.I.	Birth Date (Mo./Day/Yr.)
Street Address		City	State	Zip Code
Social Security No.	Telephone No.:		Sex: Male    Female	
<b>Dependent Care Expenses</b>				
Dependent Name(s)		Relationship		Age
1. _____		_____		_____
2. _____		_____		_____
3. _____		_____		_____
Dependent Care Provider Name _____				
Street Address _____				
City _____		State _____	Zip _____	
Tax I.D. or Social Security No. _____				
Dates of Care		Amounts		
_____		\$ _____		
_____		\$ _____		
TOTAL AMOUNT REQUESTED		\$ _____		
Provider's Signature (or attach receipt): _____				
Date: _____				
Is Provider of Service related to dependent?    Yes    No. If yes, please list age and relationship of provider: Age: _____    Relationship: _____				
I certify that the expenses listed above qualify for reimbursement and have been incurred and paid by me or by eligible members of my family. In claiming reimbursement for dependent care expenses, I certify that my spouse and I WILL NOT receive reimbursement in excess of \$5,000 from all employer sponsored dependent care accounts.				
Participant's Signature: _____ Date: _____				